TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Jeff Alan King, DC

Respondent Name
State Office of Risk Management

MFDR Tracking Number
M4-16-2536-01

Carrier's Austin Representative
Box Number 45

MFDR Date Received
April 22, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The carrier has not paid this claim in accordance and compliance with TDI-DWC Rule 133 and 134."

Amount in Dispute: $750.90

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "While the initial bills were returned to the provider for the payee identification error the written communication should have included additional information regarding the requirements on the CMS 1500 not reflecting the appropriate billing provider's required information pursuant to the aforementioned rule."

Response Submitted by: State Office of Risk Management

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 14, 2015	97750 FC	$750.90	$750.01

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.2 defines a complete bill.
3. 28 Texas Administrative Code §133.200 defines requirements of an insurance carrier receipt of medical bills from health care providers.
4. 28 Texas Administrative Code §133.10 sets out required bill submission procedures for health care providers.

5. 28 Texas Administrative Code §133.20 sets out requirements for medical claim submission.
6. 28 Texas Administrative Code §134. 204 sets out medical fee guideline for workers' compensation specific services.
7. 28 Texas Administrative Code §134.203 sets out rules and fee guidelines for professional medical services.
8. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 29 – The time limit for filing has expired
   - W3 – Additional payment made on appeal/reconsideration

Issues

1. Was a complete medical bill submitted in accordance with 28 Texas Administrative Code §133.10, 133.20 and §133.200?
2. What is the applicable rule pertaining to reimbursement?
3. Is the requestor entitled to additional reimbursement?

Findings

1. 28 Texas Administrative Code §133.20(b) requires that, except as provided in Texas Labor Code §408.0272, "a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." A review of the submitted documentation finds convincing evidence that the requestor submitted a medical bill for date of service September 14, 2015 about September 18, 2015. The respondent rejected and returned the medical bill on September 22, 2015. The respondent states, "Being that the Office utilizes the Texas State Comptroller to issue payments to our vendors there is a requirement for all vendors paid with State funds to have a Texas payee identification number. Pursuant to Rule §133.3, the Office made numerous telephonic and written attempts to the billing provider who failed to neither communicate nor submit the requested information to the Office as requested." According to 28 Texas Administrative Code §133.200, the carrier shall not return medical bills that are complete. A complete medical bill is defined at 28 Texas Administrative Code 133.2(4) in pertinent part, "Complete medical bill--A medical bill that contains all required fields as set forth in the billing instructions for the appropriate form specified in §133.10 of this chapter…" When compared to the field requirements of 28 Texas Administrative Code §133.10, the Division finds that the medical bill filed on or about September 18, 2015 was complete. The carrier's initial rejection of the medical bill is therefore not supported.

   The division concludes that the requestor timely filed a complete medical bill on or about September 18, 2015. The disputed services were filed timely in accordance with 28 Texas Administrative Code §133.20(b) and are therefore eligible for payment pursuant to the applicable medical fee guideline.

2. 28 Texas Administrative Code §134.204 (g) states,

   > The following applies to Functional Capacity Evaluations (FCEs). A maximum of three FCEs for each compensable injury shall be billed and reimbursed. FCEs ordered by the Division shall not count toward the three FCEs allowed for each compensable injury. FCEs shall be billed using CPT Code 97750 with modifier "FC." FCEs shall be reimbursed in accordance with §134.203(c)(1) of this title. Reimbursement shall be for up to a **maximum of four hours** for the initial test or for a Division ordered test; a maximum of two hours for an interim test; and, a maximum of three hours for the discharge test, unless it is the initial test.

   28 Texas Administrative Code §134.203 (c) states:

   > To determine the MAR for professional services, system participants shall apply the Medicare payment policies with minimal modifications.
   >
   > (1) For service categories of Evaluation & Management, General Medicine, Physical Medicine and Rehabilitation, Radiology, Pathology, Anesthesia, and Surgery when performed in an office setting, the established conversion factor to be applied is (date of service yearly conversion factor).

The service in dispute is 97750 with a description of – "Physical performance test or measurement (eg, musculoskeletal, functional capacity), with written report, each 15 minutes." The maximum allowable reimbursement will be calculated as follows:

Date of service	Submitted Code	Submitted Charge	Units	Allowable	MAR (DWC Conversion Factor / Medicare Conversion Factor) x Allowable = TX Fee MAR
September 14, 2015	97750 – FC	$750.90	15 (15 minutes each)	$31.97	56.2/35.9335 x $31.97 x 15 units = $750.01
	Total				$750.01

3. The total allowable reimbursement for the services in dispute is $750.01. This amount less the amount previously paid by the insurance carrier of $0.00 leaves an amount due to the requestor of $750.01. This amount is recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $750.01.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code Sections 413.031 and 413.019 (if applicable), the Division has determined that the requestor is entitled to additional reimbursement for the services in dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $750.01 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

	Peggy Miller	June , 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.